

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE
CREDENTIALING DIVISION

Expiration Date: 1/31/2007

Home Health Agency Renewal Application

IDENTIFYING INFORMATION

1. NAME AND ADDRESS OF FACILITY:

LICENSE NO: _____

TELEPHONE NUMBER: _____

FAX NUMBER: _____

ADMINISTRATOR: _____

2. PREFERRED MAILING ADDRESS (IF DIFFERENT FROM FACILITY ADDRESS) FOR THE RECEIPT OF OFFICIAL NOTICES FROM THE DEPARTMENT:

3. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: _____

4. NUMBER OF UNDUPLICATED PATIENT ADMISSIONS IN PAST YEAR: _____ FEE AMOUNT: _____

5. GEOGRAPHICAL AREAS SERVED (List by county): _____

6. ACCREDITING AGENCY: (if any)

☐ JCAHO

☐ CHAP

☐ Other _____

7. CERTIFICATION: (if any)

☐ Medicare

☐ Medicaid

8. SERVICES PROVIDED

☐ Nursing

☐ Dialysis

☐ Home Health Aide

☐ Speech Therapy

☐ Physical Therapy

☐ Intravenous Therapy

☐ Occupational Therapy

☐ Respiratory Therapy

☐ Social Work Practice

☐ Other: Please List: _____

BRANCH(ES) CURRENTLY LISTED IN OUR FILES (if any):

OWNERSHIP INFORMATION

9. OWNERSHIP OF FACILITY: _____
(Legal Name of individual or business organization)

10. BUSINESS ORGANIZATION: (Check One):

☐ Sole Proprietorship

☐ Partnership

☐ Limited Partnership

☐ Corporation

☐ Limited Liability Company

☐ Government (☐ State, ☐ District, ☐ County, ☐ City or Municipal)

☐ Other (Please Specify) _____

CERTIFICATION

I/we have read the Rules and Regulations issued by the Nebraska Department of Health and Human Services and will comply with them should a license be issued. I/we certify that to the best of my/our knowledge, all information and statements on the application are true and correct and i/we hereby apply for a renewal license.

PLEASE NOTE: Neb.Rev.Stat. Section 71-433 requires: Applications shall be signed by:

(1) the owner, if the applicant is an individual or partnership,

(2) two of its members, if the applicant is a limited liability company

(3) two of its officers, if the applicant is a corporation, or

(4) the head of the governmental unit having jurisdiction over the facility to be licensed if the applicant is a governmental unit.

AUTHORIZED REPRESENTATIVE-TYPE OR PRINT

SIGNATURE

DATE

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